

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-B
Page 4d

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: January 1, 1991

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

- (6) Hyperalimentation - Reimbursement according to the lower of the amount billed or the Title XIX maximum charge allowed.
- (7) Durable Medical Equipment (DME) - Reimbursement is based on amount billed not to exceed the Title XIX maximum.

Purchase: The Title XIX maximum for new equipment is based on Medicare's 1990 DME Fee Schedule. For those items which Medicare did not have a rate, the lowest manufacturer cost plus 10% was used. Arkansas Medicaid is following Medicare's policy of purchasing any item that costs \$150.00 or less.

Rental/Capped Rental: Capped Rental equipment may not be rented for more than 455 consecutive days. The reimbursement rates for capped rental items will be established by dividing the purchase price by 455 days to arrive at a daily rental rate. Once the 455 day rental maximum is reached, Arkansas Medicaid will cease to pay rent on the equipment, however the equipment will remain in the recipient's home as long as determined medically necessary by the recipient's physician. The equipment will remain the property of the DME company.

STATE Arkansas
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DATE EFF 1-1-91
HCFA 179 91-02

A provider may bill for maintenance, however, this maintenance fee may not be billed until either 182 days have elapsed after the 455 day rental period or 182 days have elapsed from the end of the period the item is no longer covered under the suppliers or manufacturer's warranty, whichever is later. Maintenance will continue to be paid at six month intervals if equipment is determined to be medically necessary. Reimbursement for the maintenance is the lesser of the amount billed or the Title XIX maximum. The Title XIX maximum was established by arraying all the Title XIX monthly maximums for capped rental items and utilizing the 50th percentile.

For those items which are rental only, the Medicare 1990 DME Fee Schedule monthly rental rate was used to calculate the Medicaid daily rental rate. The Medicare monthly rental rate was multiplied by 12 to determine the one year rental amount and divided by 365 to arrive at the Medicaid daily rental amount.

Supersedes 90-39

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
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Revised: October 1, 1997

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(7) Durable Medical Equipment (DME) (Continued)

DME/Nasal CPAP Device - Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum was established based on a 1989 survey conducted by the **Division of Medical Services** of four Arkansas durable medical equipment companies. Reimbursement for the nasal CPAP device is always on a rental basis only. The rate was established by utilizing the lowest monthly rental rate reflected by the survey. The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

(8) DME/Bi-Level Positive Airway Pressure (BIPAP) Equipment

Effective for claims with dates of service on or after February 1, 1995, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum for the BIPAP is based on 100% of the Medicare maximum for equipment and supplies reflected in the 1994 Arkansas Medicare Pricing File. The Medicaid monthly rental rate for equipment was used to calculate the daily rental rate. The BIPAP medical supply rate was established at 25% of the total for all supplies utilized with the BIPAP equipment. Reimbursement is a global rate for equipment, supplies and maintenance.

(9) Aerochamber Device

Effective for dates of service on or after October 1, 1997, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX (Medicaid) maximum established was based on a 1997 survey of Durable Medical Equipment (DME) providers. The information obtained in the survey indicated there is only one major manufacturer and distributor of the aerochamber devices (with or without mask) to providers enrolled in the Arkansas Medicaid Program. It was determined the aerochamber devices are sold to each provider for the same price. As a result, the current Title XIX (Medicaid) maximum for the aerochamber devices (with or without mask) was established based on the actual manufacturer's list prices. Thereafter, adjustments will be made based on the consumer price index factor to be implemented at the beginning of the appropriate State Fiscal Year, July 1.

(10) Medical Supplies

Effective for dates of service on or after October 1, 1994, reimbursement is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.1-A and Attachment 3.1-B, Item 12.C.7.

Arkansas	
DATE REC'D	July 30, 1997
DATE APP'D	September 9, 1997
DATE OF	October 1, 1997
HCHA 179	94-09

SUPERSEDES: TN - 94-08

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: April 1, 1997

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(11) Specialized Wheelchairs, Seating and Rehab Items

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. Effective for claims with dates of service on or after May 1, 1995, the Title XIX (Medicaid) maximums were established utilizing the manufacturer's current published suggested retail price less 15%. The 15% is the median of Oklahoma Medicaid which is currently retail less 12% and Texas Medicaid which is currently retail less 18%. Effective for claims with dates of service on or after September 1, 1995, the following Kaye Products, procedure codes Z2059, Z2060, Z2061 and Z2062, are reimbursed at the manufacturer's current published suggested retail price. The State Agency and affected provider association representatives will review the rates annually and negotiate any adjustments.

(12) Augmentative Communication Device

Reimbursement is based on the manufacturer's charges. Providers must submit an itemized manufacturer's invoice with the claim. Reimbursement will include the cost of the device, software, carrying case and maintenance agreement, not to exceed a maximum of \$7,500.00 If a recipient under age 21 in the Child Health Services (EPSDT) Program has met the lifetime benefit, and it is determined that additional equipment is medically necessary, the provider can request an extension of benefits. Training in the use of the device is not included and is not a covered cost. Repairs to the equipment or associated items outside the initial maintenance agreement are a covered service. Reimbursement for repairs of augmentative communication device components will be manufacturer's invoice price for parts plus 10%. Arkansas Medicaid reimburses for the labor based on the lesser of the amount billed not to exceed the Title XIX (Medicaid) maximum. The Medicaid maximum was calculated by conducting a survey of three manufacturers of augmentative communication devices who repair state-of-the art devices to the less complex devices. The three manufacturer's current hourly charge for labor was totaled, then divided by 3 to arrive at an average hourly rate. The hourly rate was divided by 4 to arrive at a 15 unit rate. Labor will be reimbursed per unit of service, (1 unit = 15 minutes limited to a maximum of 20 units per date of service allowed).

STATE	Arkansas	A
DATE	6/30/97	
DATE	7/24/97	
DATE	8/1/97	
HCFA 111	97-08	

SUPERSEDES: TN - 91-29

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: March 1, 2000

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)
- c. Prosthetic Devices (Continued)
- (13) Phototherapy (Bili-rubin) Light with Polometer

Effective for dates on or after May 1, 1999, the reimbursement rate is based on the lesser of the provider's actual charge for the service or the Title XIX maximum. The Title XIX (Medicaid) maximum was based on 100% of the Medicare maximum (daily rental rate) for the Phototherapy (Bili-rubin) Light with Polometer as reflected in the 1999 Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule. The reimbursement methodology includes a provision allowing adjustments based on fluctuations in the economy. Any adjustment to the rate will be based on the most current Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule.

STATE	<u>Arkansas</u>	A
DATE	<u>12-28-99</u>	
DATE	<u>2-4-2000</u>	
DATE	<u>3-1-2000</u>	
HCFA 179	<u>99-26</u>	

SUPERSEDES: TN. 99-02

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: March 1, 2000

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

- c. Prosthetic Devices (Continued)

(14) Orthotic Appliances and Prosthetic Devices

For Medicaid eligible recipients age 21 and over the reimbursement is based on the lesser of the provider's actual charge for the services or the Title XIX (Medicaid) Maximum. The Title XIX (Medicaid) Maximum is based on the 1999 Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule less 18%.

STATE	<u>Arkansas</u>
DATE REC'D	<u>10-28-99</u>
DATE APP'D	<u>2-4-2000</u>
DATE EFF	<u>3-1-2000</u>
HCFA 179	<u>99-26</u>

SUPERSEDES: TN. New page

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: March 1, 2000

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)
- c. Prosthetic Devices (Continued)
- d. Eyeglasses
- Negotiated statewide contract bid.
13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)
- a. Diagnostic Services - Not provided.
- b. Screening Services - Not provided.
- c. Preventive Services - Not provided.
- d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable.

The Title XIX maximum was established based on a survey by the Division of Mental Health of the usual and customary charges used by community based programs. Rates include the professional and administrative components.

For acute outpatient services and acute day treatment previously found in the Mental Health Clinic option, reimbursement is based on the lower of: (a) the provider's actual charge for the services or (b) the allowable fee from the State's fee schedule based on average cost. The average cost of each mental health service was calculated based on 1978 cost data. A 20 per cent inflation factor was applied to arrive at the "fee schedule" rate.

Effective April 1, 1988, reimbursement rates were increased 78% to reflect rates comparable to those charges found in the private sector for comparable mental health services. Effective July 1, 1991, a 20% increase was applied.

STATE	Arkansas	A
DATE	12-28-99	
DATE	2-4-2000	
DATE	3-1-2000	
HCFA 177	99-26	

SUPERSEDES: TN - 99-02

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: January 1, 1996

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

2. Extended Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Arkansas Non-State Operated Rehabilitative Hospitals

Refer to Attachment 4.19-A, Page 9a, for the reimbursement methodology, except no room and board charges will be reimbursed and the upper limit is set annually at the 70th percentile of all non-state operated rehabilitative hospitals' inflation-adjusted Medicaid per diem rate.

b. Arkansas State-Operated Rehabilitative Hospitals

Effective for claims with dates of service on or after 1-1-96, Arkansas State Operated Rehabilitative Hospitals are classified as a separate class group. The Medicaid definition of a state operated rehabilitative hospital is: A hospital that is recognized as a state operated rehabilitative facility.

The per diem reimbursement for Rehabilitative Services for Persons with Physical Disabilities (RSPD) provided by a State Operated Rehabilitative Hospital will be in accordance with the reimbursement methodology in Attachment 4.19-A, Page 9a, except; the initial per diem rate will be capped at \$232.00, no room and board charges will be reimbursed and the annual inflation factor will be based on the HCFA Market Basket Index forecasts published by the HCFA Regional Office for the quarter ending in September. The inflation factor used is taken from the Excluded Hospital Input Price Index category. Arkansas Medicaid will review the per diem rate annually and adjust the rate, if necessary, based on the provider's unaudited cost report, and the annual inflation factor.

STATE <u>Arkansas</u>	A
DATE REC'D <u>11-06-95</u>	
DATE APP'D <u>12-18-95</u>	
DATE EFF <u>01-01-96</u>	
HCFA 179 <u>95-24</u>	

SUPERSEDES: TN - 95-01

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February 15, 1995

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

Not provided.

b. Nursing facility services

Not provided.

STATE <u>Arkansas</u>		A
DATE REC'D	<u>JAN 12 1995</u>	
DATE ADJ'D	<u>FEB 22 1995</u>	
DATE LFT	<u>FEB 15 1995</u>	
HCFA 179	<u>93-01</u>	

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SUPERSEDES: 94-15

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
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Revised: September 1, 1995

15. Services in an intermediate care facility for the mentally retarded, as defined in Section 1905(d), (Other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

SEE ATTACHMENT 4.19-D

16. Inpatient Psychiatric Facility Services For Individuals Under 22 Years of Age

Effective for dates of service on or after July 6, 1992, reimbursement for residential treatment facilities is based on the lesser of the budgeted cost per day which includes the professional component or a limit of \$350.00 per day with no cost settlement. The budgeted cost per day is based on the provider's current budget information. Arkansas Medicaid will negotiate with the Arkansas Hospital Association annually (State Fiscal Year - July 1 through June 30) regarding adjustment of the rate and/or the \$350.00 per day limit. The Inpatient Psychiatric Hospital reimbursement methodology is reflected on Attachment 4.19-A, Page 9b.

Sexual Offender Programs

Sexual Offender Programs are designed specifically for the treatment of those patients designated as sexual offenders who cannot be treated with other mental health patients. These services are provided in separate units in the psychiatric facility. These units meet all the requirements of Subpart D of 42 CFR Part 441 for inpatient psychiatric services for individuals under 21. In addition, they must meet any certification requirements of the Division of Mental Health Services.

Effective for cost reporting periods beginning on or after September 1, 1995, these providers will be reimbursed using Medicare Principles of Reasonable Cost Reimbursement, in 42 CFR Part 413, subject to cost settlement. The initial interim rates for these programs will use reasonable budgeted cost reports. Once audited cost reports are available the most recent audited cost report will be used to set the interim rate. Interim rates will be adjusted every six months if costs increase more than 10%.

Year end cost reports must be submitted and will be audited in the same manner as audits for inpatient psychiatric hospitals and will be cost settled.

STATE	Arkansas	
DATE	07-20-95	
DATE	10-10-95	
DATE	09-01-95	A
HCFA 177	95-22	

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Revised: July 1, 1997

17. Nurse Midwife Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum. The Title Maximum for nurse-midwife services was established based on 80% of the current physician Medicaid Maximum. Rhogam RhoD Immune Globulin is reimbursed at the same rate as the physician's rate since the cost and administration of the drug does not vary between the nurse midwife and physician.

MAXIMUM MEDICAID PAYMENT RATES FOR OBSTETRICAL SERVICES

<u>Procedure Code</u>	<u>Procedure Description</u>	<u>Maximum Payment</u>
<u>MIDWIFE</u>		
Z0637	Initial Prenatal Visit	\$48.00
Z0638	3rd Month Prenatal Visit	\$19.20
Z0639	4th Month Prenatal Visit	\$19.20
Z0640	5th Month Prenatal Visit	\$19.20
Z0641	6th Month Prenatal Visit	\$19.20
Z0642	7th Month Prenatal Visit	\$19.20
• Z0643	8th Month Prenatal Visit	\$38.40
Z0644	9th Month Prenatal Visit	\$76.80
Z0670	Vaginal Delivery with Postpartum Care	\$361.60
Z0671	Total Antepartum and Postpartum Care and Delivery	\$752.00
Z1751	Routine Newborn Care/Nurse Midwife	\$78.66
Z1752	Newborn 6 Week Checkup/Nurse Midwife	\$19.20
J2790	Rhogam RhoD Immune Globulin	\$39.50

STATE <u>Arkansas</u>	A
DATE REC'D <u>5-6-97</u>	
DATE APP <u>7-30-97</u>	
DATE EFF <u>7-1-97</u>	
HCFA 179 <u>97-02</u>	

SUPERSEDES: TN 96-10